



Capitol Insights Newsletter April 17, 2026

Author(s): Matt Reiter

What Happened in Congress This Week?

HHS Secretary Robert F. Kennedy Jr. testified before the [House Ways and Means Committee](#) and the [House Appropriations Committee](#) about the White House Budget Request for HHS and other topics. He is testifying before the [House Education and Workforce Committee](#) today. He is scheduled to testify before the [Senate HELP Committee](#) and the [Senate Appropriations Committee](#) next week.

The Senate HELP Committee held a [hearing](#) on lowering prescription drug prices that spent significant time discussing the role of biosimilars as a cheaper option for consumers.

CMS Proposes Expanding Prior Authorization Regulations to Drugs

Congress continues to consider legislation to address administrative burdens and care disruptions from excessive prior authorization requirements. Legislation such as the Improving Seniors Timely Access to Care Act has not passed despite large bipartisan support. Meanwhile, the Centers for Medicare and Medicaid Services (CMS) has proactively used its regulatory authorities to make needed changes to the prior authorization process.

In 2024, CMS finalized a [regulation](#) that would implement much of the Improving Seniors Timely Access to Care Act's provisions. The rule, which partially took effect this year before fully taking effect next year, requires federally-regulated health plans (Medicare Advantage, Medicaid Managed Care, CHIP, and ACA plans) to abide by an electronic process for prior authorizations. It also standardizes the timelines by which health plans must respond to prior authorization requests and improves transparency.

This rule was the most significant federal action to improve the burdensome prior authorization process. However, it notably excluded drugs.

CMS is now [proposing](#) an important expansion of its 2024 final rule that, if finalized, would add drugs into this existing regulatory framework.

Electronic Interoperability

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The existing final rule establishes a FHIR-based API to facilitate interoperable electronic prior authorization requests. CMS is proposing to require prior authorizations for drugs under this same API framework. The FHIR-based API is not required until January 1, 2027.

Response Timelines

Under the existing regulations, health plans currently have seven days to respond to prior authorization requests (72 hours for expedited requests). CMS is proposing to require responses to prior authorization requests for drugs within 24 hours for most health plans (ACA plans would have 72 hours for standard and requests and 24 hours for expedited requests), effective October 1, 2027.

Transparency

The proposed rule would expand the existing regulatory requirement for health plans to communicate a specific reason for denying prior authorization requests for any drugs.

The 2024 final rule requires that impacted payers annually report prior authorization metrics for non-drug items and services on their public websites. CMS is proposing to add requirements for impacted payers to report the numeric counts in addition to percentages for certain existing metrics, as well as for impacted payers to publicly report additional prior authorization metrics.

Requests for Information

The proposed rule includes requests for information (RFIs) on how CMS can take regulatory action on topics such as admission, discharge, and transfer (ADT) notifications, cybersecurity, and step therapy.

Next Steps

CMS is now collecting public comments on the rule and responses to the RFIs until June 15th. CMS will then need to issue a final version of the rule that addresses the public comments it receives.

Top Stories in Healthcare Policy

President Trump nominated Dr. Erica Schwartz to be the next CDC Director. Dr. Schwartz previously served as Deputy Surgeon General during the first Trump Administration.

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CMS **announced** the initial set of 700 vendors that are participating in its Health Tech Ecosystem Initiative.

CMS **published** the CY 2027 Hospital Inpatient Prospective Payment System (IPPS) proposed rule, which would increase hospital inpatient payments by 2.4% and expand the Comprehensive Care for Joint Replacement (CJR) into a mandatory, national payment model.

A California judge **dismissed** a lawsuit by Elevance Health against organizations that initiated large volumes of No Surprises Act IDR Disputes.

14% of people enrolled in ACA coverage **have not paid** their first month's premium.

A **study** of over 410,000 patients found an association between unmet social needs and higher healthcare costs.

A new **study** highlights how increasing utilization of patient portals contributes to clinician burnout.

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